PAGE

PRINTED: 08/18/2015

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION DENTIFICATION NUMBER: COMPLETED A. BUILDING: 01 B. WING HAL057010 08/11/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 170 SOUTH MAIN STREET MARS HILL RETIREMENT COMMUNITY MARS HILL, NC 28754 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) C 000 Initial Comments C 000 Report of Biennial Construction Survey by Dennis CONSTRUCTION SECTION Harrell and Greg Cates on 8-11-2015. SEP 0 1 2015 Records indicate this facility was first licensed or submitted 3-5-1998, for a capacity of 69. RECEIVED Therefore the facility was surveyed for conformance with the 1996 Rules for the Licensing of Adult Care Homes, the applicable portions of the 2005 Rules for Adult Care Homes of Seven or More Beds, and the 1998 North Carolina Building Code for Institutional Unrestrained Occupancies. C 111 Must Have Current San. & Fire Safety Reports C 111 ARRANGEMENTS WERE MADE POR FIRE MARSHALL SECTION .0300 - PHYSICAL PLANT TO COME BY. 10A NCAC 13F .0302 DESIGN AND CONSTRUCTION( The facility shall have current sanitation and fire and building safety inspection reports which shall be maintained in the home and available for review. This Rule is not met as evidenced by: Based on a review of documents, the required annual fire alarm system inspection report could not be located. Fire alarm systems that are not inspected and approved as required could result in the fire alarm system not operating properly in the event of an actual fire. C 166; Housekeeping-Maintained Free of Hazards C 166 SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0306 HOUSEKEEPING AND FURNISHINGS (a) Adult care homes shall: (5) be maintained in an uncluttered, clean and

Ivision of Health Service Regulation

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVES SIGN

TITLE

ADMINISTRATOR

(NE) DATE

If continuation sheet 1 of 6

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Division	of Health Service Re	egulation			1 011	A THOTED
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIP	LE CONSTRUCTION		SURVEY	
DENTIFICATION NUMBER:		A. BUILDING	: 01	COM	PLETED	
			B, WING			
		HAL057010	B. 14MO		08/	11/2015
NAME OF	PROVIDER OR SUPPLIER		T ADDRESS, CITY,			
MARS H	ILL RETIREMENT CO	MMUNITY	OUTH MAIN ST BHILL, NC 2870			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	ON	(205)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	COMPLETE DATE
C 166	Continued From pa	ge 1	C 166			
	hazards;	e of all obstructions and apply to new and existing				The same and the s
	employee bathroom bathroom was obstr a weight scales cha	at as evidenced by: on, the access to the n and the room behind the ructed with 4 wheel chairs a ir. Obstructed access to the ise a trip and fall hazard,		COMPLETED		8/24/15
C 189	Building Equipment	Maintained Safe, Operating	g C 189			
	mechanical, and plu care home shall be operating condition. (k) This Rule shall a facilities with the ex-	11 OTHER d all fire safety, electrical, ambing equipment in an ad- maintained in a safe and	uit			
	doors throughtout th latching hardware. 'by activation of the f doors failed to close when closed. Cross close completely an that a fire that begin spread through the of the facility. Findings include:	ration, the cross-corridor ne building are equipped wit When the doors were close fire alarm system, many of completely and/or latch corridor doors that do not d latch present the possibility in one space can quickly corridor to the remainder of	ed the ity	COMPLETED		8/22/15
	<ul> <li>a. One of the cross</li> </ul>	-corridor doors near room 2	215	Configuration		8/23/15

3MC021

	of Health Service Re	egulation					
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DAYE SURVEY COMPLETED			
		HAL057010		B. WING	A Company of the Comp	08/1	1/2015
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY,	STATE, ZIP CODE		
MADEH	ILL RETIREMENT CO	MANUAL INCOME.	170 SOUT	H MAIN ST	REET		
marks II	TEL RETIREMENT CO	MINUNIT	MARS HIL	.L, NC 2875	4		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENT MUST BE PRECEDED SCIDENTIFYING INFOR	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
C 189	Continued From pa	ge 2		C 189			
C 189	failed to latch when b. One of the cross failed to latch when c. One of the cross failed to latch when d. One of the cross failed to latch when d. One of the cross failed to close compclosed.  2. Based on observare prevented from resist the passage of doors that do not clopresent the possibilitione space can quick the remainder of the Findings include; a. The door from the wedged open. This the stairs that are op the floor above.  b. One of the pair of the corridor was wedged d. The door from the corridor would not late. The door from the corridor would not late. The door from the corridor would not late. The door from the linen room was drag completely.	closed. corridor doors no closing quickly an of fire and smoke. cose completely an ity that a fire that be key spread to the of e facility.  e kitchen to dining situation was exa coen from the dining of doors from the di agged and could a e resident laundry d open. e clean linen room atch when closed. e main laundry to	ear room 345 ear room 353 ear room 40 ear room 4	C 189	COMPLETED		8/28/15
	f. The door to the m Activity Office was h					!	
	<ol> <li>Based on observenthe South end of the several chairs to the blocked from opening could delay or preventhere.</li> </ol>	facility was obstru- point that one exi- ig fully. Obstructe	ucted with t door was d exit paths				

	of Health Service R	egulation			FORMAPPROVEL
		(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION 5: 01	(X3) DATE SURVEY COMPLETED
		HAL057010	B, WING		08/11/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE	
MARS H	LL RETIREMENT CO	DMMUNITY	TH MAIN ST		
		MARS HI	LL, NC 287	54	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
C 189	Continued From pa	nge 3	C 189		
.	emergency lights in when tested. Batte that will not work produld endanger the Findings include; a. The battery pow 1st floor central stab. The battery pow 3rd floor North stair.  5. Based on observantations are be working on battery.	vation, some battery powered in the stairwells would not work any powered emergency lights roperly for at least 90 minutes a residents and staff.  Wered emergency light in the sirwell would not work, wered emergency light in the well would not work.  I wation, the facility failed to be cause of exits signs not back-up. Exit signs that fail to be evacuation in an emergency.		WILL BE COMPLETE	n 9/9/15
	Findings include; a. The exit sign 3rd work on battery.	d floor North exit would not			
	removed for the due the 3rd floor mecha station. Duct smok their covers endang	vation, the exterior cover was of mounted smoke detector in inical room behind the nurse's e detectors that are missing ger all residents and staff efector can't operate properly.		COMPLETED	8/24/13
	fire rated walls and/ in several locations, are not sealed with one-hour fire rated o ceiling radiation dan that a fire that begin spread to other area Findings include: a. The gypsum com	vation the required one-hour for ceilings were compromised. Holes and penetrations that materials approved for use in construction and inoperable in pers present the possibility is in one space can quickly as of the facility.		WILL BE COMPLETE	50 9/9/is

Division of Health Service Regulation						,
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY	_	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	c 01	COMPLETED	
		HAL057010	B. WING		08/11/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	ORESS, CITY.	STATE, ZIP CODE		
*****		170 8010	TH MAIN ST	,		
MARS H	ILL RETIREMENT CO	MMUNITY MARS HI	LL, NC 287	54		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		Т
PREFIX		MUST BE PRECEDED BY FULL 9C IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROX		
		,	1 1/10	DEFICIENCY)		
C 189	Continued From pa	ge 4	C 189			٦
		_	0 100		ĺ	
	behind the nurse's					-
		n the communication room.				ı
	room.	it sleeve in the communication			1	١
		tion dampers in the exhaust				١
		throughout the facility.				١
		,				١
		ation, there were many items				ł
		nt of the electrical panels in				١
		oom. Storage in front of				١
		Building Code violation and				١
	_	to the electrical disconnects in				ı
	an emergency.					١
	9. Based on observ	ation, the toilet in the 1st floor				١
		was clogged and inoperable.				ı
		,			01.1.	1
i		vation, the dryer in the		WILL BIE COMPLIETIE	0 9/5/15	ł
- }		fallen apart, Dryer ducts		WILL DIE	, ,	1
ĺ	and combustible lint	ned intact, introduce moist air			İ	١
'	and compastible line	into the room,				ı
C 199	Exhaust Ventilation		C 199			1
	Exhaust verillation		0 100		!	1
1	SECTION .0300 - P	HYSICAL PLANT			1	ı
į	10A NCAC 13F .031	1 OTHER				١
	REQUIREMENTS					ı
		d in this Paragraph shall be				١
		st ventilation at the rate of				ı
		inute per square foot. This				ı
		of apply to facilities licensed with natural ventilation in				
[	these specified space					
	(1) soiled linen stora					I
	(2) soil utility room;	-				ı
	(3) bathrooms and t	oilet rooms;				1
	<ul><li>(4) housekeeping cl</li></ul>	osets; and			i.	1
	(5) laundry area.				ŀ	
	<ul><li>(k) This Rule shall a</li></ul>	pply to new and existing				1

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	of Health Service Re	agulation			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION 3: 01	(X3) DATE SURVEY COMPLETED	
		HAL057010	B. WING		08/11/2015
NAME OF R	PROVIDER OR SUPPLIER	STREET AC	DDRESS, CITY,	STATE, ZIP CODE	
MADE H	ILL RETIREMENT CO	470 0000	TH MAIN ST	•	
MARS	LL RETIREMENT GO	MMUNITY MARS HI	LL, NC 2875	54	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX YAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES (CROSS-REFERENCE)	D BE COMPLETE
C 199	Continued From pa	ige 5	C 199	ALL COMPLETIED	8-25-19
C 199	facilities with the ex- which shall not application. This Rule is not me Based on observation of the being maintained in building. Findings include: a. There was a patt working in houseker throughout the build room, b. No exhaust system.	et as evidenced by: ion, required exhaust was not in many spaces throughout the ttern of exhaust vents not eeping closets and bathrooms ding and in the trash storage em was provided in a age closet on the 1st floor	C 199	ALL COMPLETIED EXCEPT b.	

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